

**Access to healthcare,
mortality and violence in
Democratic Republic of the Congo**

**Summary of the results of
five epidemiological surveys:
Kilwa, Inongo, Basankusu, Lubutu, Bunkeya
March to May 2005**



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The full report on the five surveys will be available on our website www.msf.be from 15 November 2005.

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Context

The Democratic Republic of the Congo (DRC) is today in a transition phase. The signature of the Global and Inclusive Agreement on Transition, in Pretoria on December 16, 2002, the nomination of a National Union government and the presentation of an electoral calendar have rekindled hopes of peace and better tomorrows. However, many eastern regions of the country, from Ituri to Katanga, and including Kivu and Maniema, are still in a state of war¹.

The international community seems agreed in acknowledging that statistics for DRC are sombre indeed. Health indicators are as alarming as the hardship faced by these poverty-stricken people.

At a time when DRC and the international community are working on transition and economic reconstruction, it is crucial that the dire humanitarian and health situation in which the Congolese population finds itself in **still today** not be overlooked. This situation calls for the deployment of far-reaching policies focused on the **immediate needs** of this population.

Surveys and method

In early 2005, MSF carried out a series of surveys following the model used for surveys done in 2001. The new surveys were conducted in five health zones: Kilwa, Inongo, Basankusu, Lubutu and Bunkeya². Three of these zones had previously been surveyed in 2001.

The new surveys focus on **mortality, access to healthcare, vaccination and violence**. Their objective is to depict to the international community the situation prevailing in DRC and to contribute to the adjustment of MSF's programmes.

The retrospective mortality rates, as well the results relating to access to healthcare, vaccination, violence, and the interaction between all of these parameters, have been estimated using the WHO's two-degree cluster sampling method. In each of the zones, 900 households were interviewed between March and May 2005.

For questions relating to mortality and access to healthcare, the retrospective period included the months having elapsed since the beginning of the year up to the day of the survey. For questions relating to violence, the retrospective period covered these same months and the year 2004.

The questionnaire comprised 23 questions and the data were entered on a daily and/or weekly basis in the Epi Info 6.04 fr programme and verified upon the return of the field supervisors. The analysis was conducted in Brussels. Given the sampling method used, the results have not been extrapolated over a larger area, but could nevertheless be indicative of the situation elsewhere.

This MSF undertaking is part of many years of sustained efforts to draw attention to the plight of the Congolese people living in hardship and misery far from media and public attention³.

¹ *Democratic Republic of Congo – Nothing new in Ituri: The violence continues*, MSF report, August 2005. Available on <http://www.msf.ch>

² Of these zones, Basankusu and Kilwa are partially supported by MSF. Bunkeya receives aid from a Spanish congregation, and the health zones of Lubutu and Inongo have no outside assistance.

³ *Silence on meurt*, MSF-B, Editions l'Harmattan, 2003; *Accès aux soins et violences au Congo, Résultats de cinq enquêtes épidémiologiques*, MSF-B, December 2001; *CONGO 2000 – Santé d'Etat, Etat de santé*, MSF-B, 2000; *Populations en danger au Zaïre*, MSF-B, 1993.

Results and discussion

I. Mortality

The Crude Mortality Rate (CMR) in a stable population in developing countries is estimated at around 0.5/10,000/day (for industrialized countries, this rate is around 0.3). A CMR of more than 1/10,000/day indicates a state of emergency. The situation is declared a catastrophe when this rate exceeds 2/10,000/day.

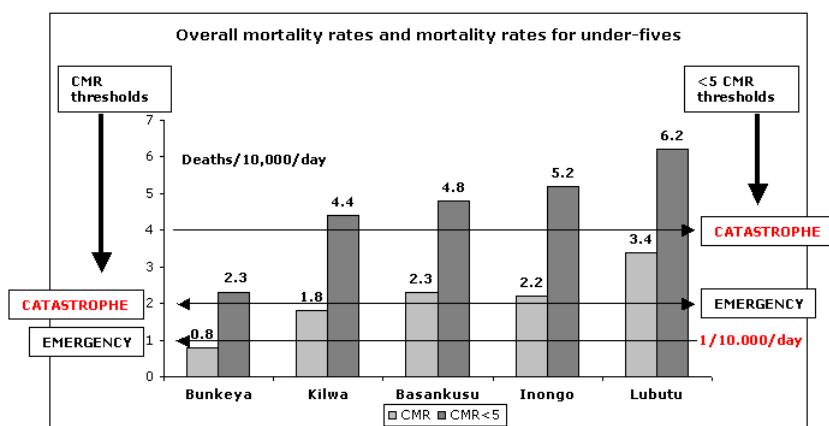
For under-fives (MR<5): the normal rate is 1/10,000/day and a state of emergency is reached when the rate exceeds 2/10,000/day. The situation is declared a catastrophe when the rate exceeds 4/10,000/day.

For over-fives (MR>5): the normal, emergency and catastrophe rates are 0.4, 0.8 and 1.6/10,000/day respectively.



The mortality figures are indicative of a state of emergency in four of the five zones surveyed. In three of the five zones, the figures reveal a **catastrophic health situation**.

Despite political changes, the mortality figures show no significant improvement. Indeed, the situation in some of the zones surveyed has worsened since the surveys of 2001.



Mortality rates among the population aged five and over are also very high in some of the zones surveyed, which is a further indication of the degree of severity of the crisis.

The most common causes of mortality identified during the surveys are infectious diseases such as malaria, diarrhoea and acute respiratory infections. These diseases could be avoided and treated if some form of decent healthcare were available.

Malaria is the most frequently reported cause of death.

II. Access to healthcare

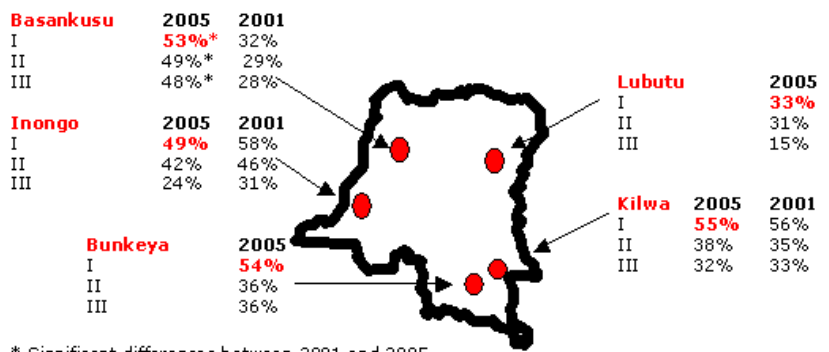
To determine accessibility or non-accessibility to healthcare, we defined access to healthcare as follows:

'Total' access (I), includes **all consultations outside the family** (private, public, traditional, dispensary) resulting in access to full treatment (irrespective of place of treatment);

MPH⁴ access (II) includes patients who attended a **consultation in a public structure**, irrespective of place of treatment;

MPH access (III) same place refers to patients who had consultations and received treatment within the same public medical facility.

Access to healthcare (I) is generally very poor, since – except for a few slight differences – it is available to only one in two people in four zones. It is clearly inadequate in Lubutu where only one in three people has access to any healthcare.



* Significant differences between 2001 and 2005



Full access in the public health service (III) is at an even lower level. It is available to only one in two patients in the best of cases in Basankusu, and to one in three in Kilwa and Bunkeya. It is markedly lower in the unsupported zones, where it applies to only one in five patients in Inongo and one in six in Lubutu.

Between 2001 and 2005, access improved in Basankusu, remained unchanged in Kilwa and decreased in Inongo.

Overall, in the surveyed zones, non-access affects between 45% and 67% of people who are ill. Non-access means that people who fall sick are totally excluded from any form of healthcare and/or do not receive treatment prescribed, in part or in whole.

Exclusion

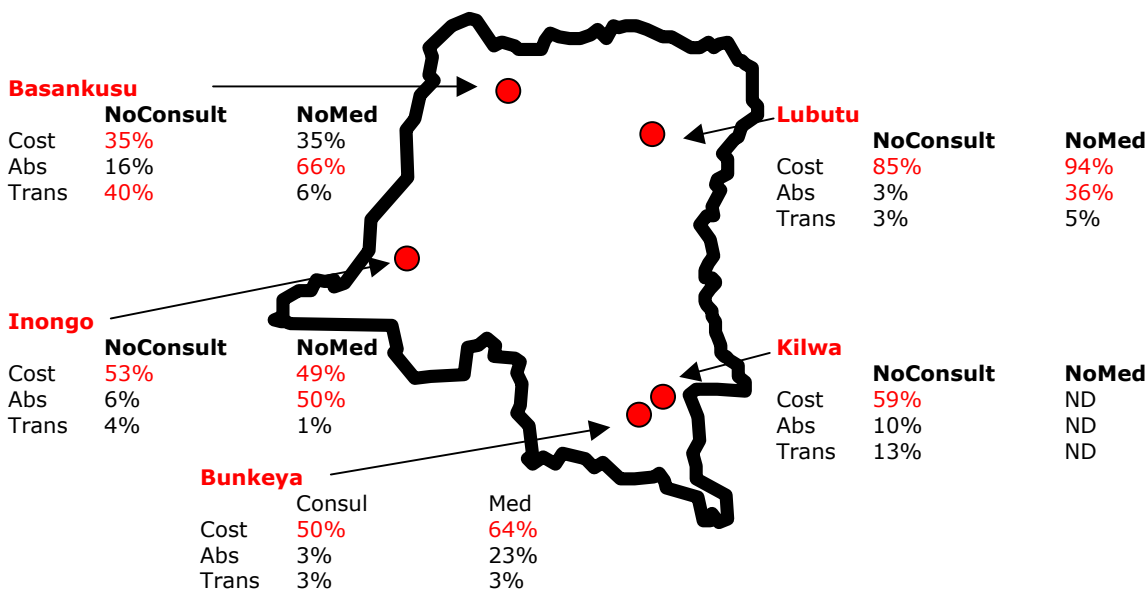
People who sought no consultation outside the family during their last episode of illness are considered to be totally excluded from healthcare. Total exclusion is high in all zones and varies between 29% and 38% of people who suffered an illness.

Incomplete treatment

Incomplete treatment affects 20% to 48% of patients who were prescribed treatment, depending on the zone. The figures are especially high for Lubutu, where nearly half of the patients did not obtain full treatment.

⁴ MPH: Ministry of Public Health

Reasons for exclusion and non-accessibility of treatment: cost, non-availability of medicines, distance and recourse to self-medication and alternative medicine



Legend
 NoConsult = no consultation Abs = Absence
 NoMed = no medicines Trans = Transport

o **The financial barrier**

"We live in the village of Mbiliona where the health centre is not working, and the nearest MSF-supported centre is over 40km away. Our child got sick in February 2005. He was six weeks old and had a respiratory infection. A man selling medicines came to the village and asked us for 600 francs for three doses of an injectable treatment. My husband and I tried to find all the money we could, which was only 300 francs. The man told us that was only enough for a single dose. Our child died a few days later."

Mrs C.
Basankusu health zone

The barrier of cost is in all cases, aside from transport in Basankusu, the main reason that people did not have medical consultations or receive medicines. Those interviewed spoke of "lack of money".

The majority of the Congolese population lives in poverty with, on average, the equivalent of \$0.30 (US dollars) per person per day on which to survive.

Moreover, in a country where economic activity is at a virtual standstill outside the big towns and where the potential for income-generating activities is very limited, the physical availability of cash is a problem. This demonetisation linked to isolation and the currency exchange deficit cannot be underestimated. Money that does not exist cannot circulate.

Despite this reality, all the formal health structures require patients to make a financial contribution; all medical services must be paid for in cash. Unless they can pay, patients do not have access to healthcare, barring a few exceptions with loans and exemptions which are somewhat theoretical and strictly limited. During the survey, we observed highly variable primary healthcare charges depending on the zones⁵: between 20 Congolese francs (\$0.04) in supported structures such as in Basankusu and 2,100 francs (\$4.20) in Lubutu.

⁵ See full report.

"We live in the village of Loolo, 52km from Waka. Our five-year-old child had diarrhoea and we decided to use our own medicine because there is no health centre we could afford nearby. As the situation got worse, we decided to go to Waka, where we thought we might be able to get treatment. When we arrived there after a long journey, our child was dehydrated and they had no IV drips available so our child died."

Mr D.
Basankusu health zone

○ **The non-availability of medicines**

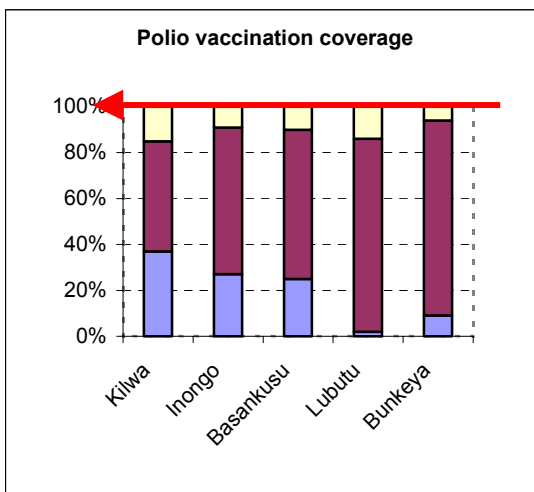
The non-availability of medicines is another major obstacle. Getting supplies is always a problem, even in supported zones. The dispensaries in public healthcare facilities are not supplied regularly. When stocks run out, the health officials send patients with their prescriptions to itinerant vendors or to pharmacists, most of whom are not professionals and who sell medicines at high prices or of dubious quality.

○ **The barrier of distance**

Distance is an obstacle for access to healthcare: the roads are bad and means of transport limited and costly. There is uncertainty when setting out on a long journey, as the availability of medicines at the health centre or the presence of nursing staff is never guaranteed. Travel is often undertaken as a last resort when there is little hope left or it is too late.

○ **Recourse to self-medication and alternative medicine**

Self-medication and traditional medicine, or evangelical churches, are popular options in rural areas, often due to a lack of alternative. This unregulated parallel market offers good and not-so-good services, much like the official healthcare system.

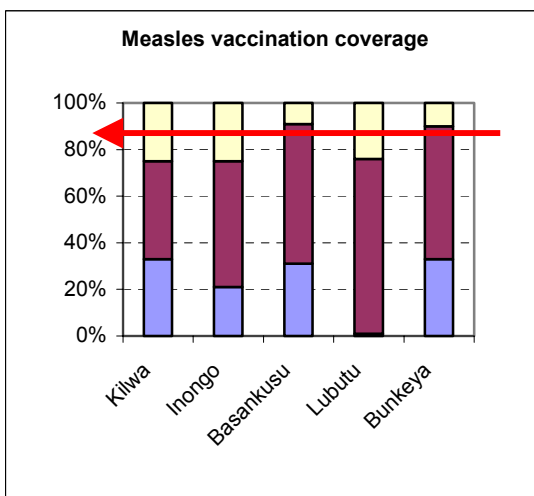


III. Vaccination

Despite the many efforts and resources deployed by various healthcare partners, including MSF in the case of measles, vaccination coverage is far from comprehensive in the zones visited.

Vaccine cover against **polio** varies from 84% in Bunkeya to 91% in Basankusu and Inongo. These results differ from those advanced by the national programme, which are based on the number of vaccines administered and estimated population figures. The number of unvaccinated children has risen in 2005 compared to the results obtained in the zones surveyed in 2001. The level of non-vaccination is up from 4 % to 9.2% in Basankusu, from 3.4% to 14.8% in Kilwa, and from 0.7 % to 9.2% in Inongo.

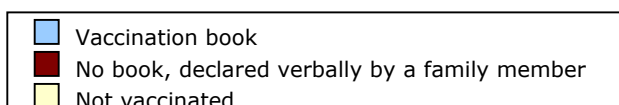
Vaccination coverage against **measles** remains insufficient (less than 85%). In Kilwa, Inongo and Lubutu, one quarter of the children have not been vaccinated. Where poverty and regular measles epidemics are rife, the importance of increased coverage is obvious.



Although still insufficient, an increase in coverage since 2001 can be observed in the zones of Inongo, Basankusu and Kilwa. More often than not, the survey findings corroborate those of the MPH, with the exception of those for Lubutu and Kilwa, where coverage appears to be lower than indicated.

As with medicines, vaccination calls for highly efficient logistics and vast human, technical and financial resources if it is to be regular and effective.

← Minimum vaccination thresholds for the eradication of polio (100%) and anti-measles coverage (85%)



IV. Violence

"On March 12, 2005, I had gone to sell fufou to make some money for my husband's tuition fees. When I returned at around 11am, we heard gunfire from all around the (diamond) quarry in Tokobika. I was taken away by armed men far into the forest. They raped me and made me be like their wife for two days. On the third day, I managed to escape when they sent me to fetch water from the river. I spent the whole night in the forest and then made my way to the main road to Lubutu at around 2pm."

Mrs A.
Lubutu health zone

In the east of the country, the situation remains unstable from the territory of Ituri to the north, to Upper Katanga to the south, and across Kivu and Maniema. The findings for Lubutu are testimony to this horrendous reality, with 72% of families having reported being victims of violence in 2004 and/or 2005, and 76% having had to flee their homes to safety during this same period. A climate of virtually permanent violence prevails, with nearly two-thirds of the families telling us they had been robbed at some time or other.

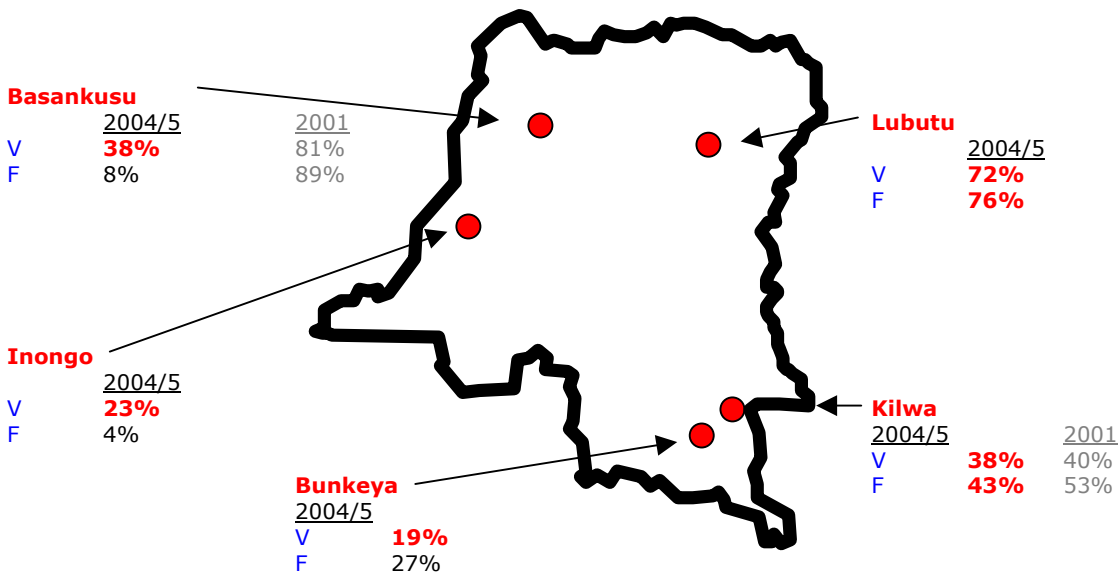
Moreover, Lubutu has a very high incidence of sexual violence. 5% of the families interviewed reported one case of rape either in 2004 or during the first four months of 2005. This high incidence of sexual violence in early 2005 is in sharp contrast with the total lack of medical care or any other support for these women.

Mortality rates among the families exposed to violence are significantly higher than among those not exposed to violence.

The zones of Bunkeya and Kilwa experience sporadic outbreaks of violence to a lesser extent, with 19% and 38% respectively of families reporting violent attacks, and 27% to 43% of families forced to flee. Direct and indirect reports, for Bunkeya and Kilwa, tell of the presence of numerous rival armed factions, some allegedly seeking merely to survive, others to uphold a fragile power base.

Inongo and Basankusu are zones that have not been spared by this indicator of instability, either: 23% and 37% of families have reportedly been victims of violence. Here, however, the violence is due more to civil disorder, unlike the other three zones (where it is more military violence).

Victims of violence and those forced to flee to safety



Legend

V= Victims of violence
F=Forced to flee

* Reported forms of violence include: theft, arson attacks, imprisonment (with torture), beatings, shootings or stabbings, landmines, rape and enlistment under coercion.

Conclusions

❖ Dire health conditions in the zones surveyed

In 2001, as war raged in DRC, MSF called on the international community to respond to the extreme gravity of the health conditions of the population. Our teams had conducted a series of surveys in five health zones throughout four provinces in Congolese territory: Basankusu, Kilwa, Inongo, Lisala and Kimpangu.

In 2005, the findings of our surveys **conducted in peace time** show an even darker picture of the health situation than MSF had reported four years previously:

- **Catastrophic mortality rates**

In absolute terms, for all of the zones surveyed (735,700 inhabitants), an estimated 12,060 people died over a 75-day period, while the expected death rate in the zone (expected rate of 0.5/10,000/day) for this period was 2,760 deaths. Over this period, **excess mortality is 9,300 deaths** for all of the zones surveyed.

The expected number of deaths per day was 37. We noted 161 deaths per day, which means that the expected number of deaths was exceeded by 124.

- **In the zones still afflicted by war today, infectious diseases and malnutrition are the deadly allies of the violence.**
- **Excess mortality is not confined solely to the war-torn regions of the country.**

The excess mortality rate in DRC should not be associated solely with the conflict on-going in some areas of the country.

Extreme poverty and hardship are today just as deadly.

Most Congolese live in absolute poverty. In the rural areas, most of the families are vulnerable and sickness or disease are regarded as a tragedy. Just like four years ago, most of the victims are still dying in silence, while the world's attention is elsewhere.

❖ Very little access to healthcare for needy populations

In four of the five zones surveyed, **1 in 2 people** had no access to any form of healthcare outside the family at the time of the last episode of illness (50%). This figure rises to more than **2 in 3 people** having no access to healthcare whatsoever in the Lubutu zone (69%).

In the light of our latest survey findings and field experience gained over the years, the main barriers for access to healthcare in DRC are:

- inadequacy or non-existence of healthcare provision
- patients' inability to pay for healthcare
- non-availability of quality medication
- lack of supervision and training of medical personnel
- non-payment of health workers' and officials' salaries
- geographical inaccessibility and non-existence of the communication structures needed for the long distances between where patients live and the nearest health centre.

Lack of medical facilities to meet the needs of the population

Medical facilities are either non-existent or inadequate in all of the zones surveyed.

Owing to a lack of structural amenities and financial support, the health sector is left to fend for itself and cannot cope with the needs of the Congolese people.

The quality of the care available is also a problem. Practically abandoned with virtually no resources, medical teams are unable to provide care under decent conditions. During our survey of areas receiving no outside help, our field observers found:

- health structures that were unstaffed or without trained personnel
- health structures with medical personnel, but no equipment or medication
- health catchment areas without any medical structures.

With the public health system thus still unable to respond to the demand for healthcare, the population is often left with no alternative. Where a private (profit-making) alternative exists, it is rarely accessible to the population due to its high cost.

In isolated areas and/or where no alternative exists, the only recourse is to the informal sector, i.e. alternative medicine or self-medication. As this sector is virtually impossible to regulate, those who resort to it often do so at great risk to their health.

A major barrier: financial exclusion

- In the zones surveyed by MSF where there is ***no outside support***, there is a cost-recovery system in force. What patients have to pay in public structures in the health zones of Inongo and Lubutu varies between the equivalent of \$2.50 and \$4.20 for a primary healthcare consultation. These charges can be up to 100 times higher in supported structures, such as in Basankusu.

In these zones, a great many of those questioned said that they were unable to pay for healthcare. Over 80% of the Congolese subsist on the equivalent of \$0.30 per person per day, so the cost of primary medical care places an unbearable financial burden on families.

- ***In the MSF-supported health catchment areas in Basankusu***, the charge to patients is 20 Congolese francs (\$0.04 US dollars).

In these areas, the exclusion percentage is considerably lower for patients in the families interviewed. Yet, in spite of more affordable charges, financial exclusion still persists, albeit to a lesser extent.

These differences demonstrate just how much the financial barrier affects access to healthcare, however low the cost may be.



Implications of the survey findings for MSF-B

These survey findings indicate the changes needed to improve the impact of MSF's work. The measures to be taken or stepped up include:

- No longer charging patients the flat fee. Although the amount patients are asked to pay in our projects is considered very low, it is still a barrier for them. **MSF-B will therefore be providing basic healthcare free of charge in the supported structures.** More effort will be put into informing people of this. There will also be close monitoring of how this policy is put into effect.
- More outreach or mobile activities to get to the most vulnerable groups and those who have little or no access to healthcare. There will also have to be a strengthening of reference networks, with practical support for referral patients.
- Addressing the issue of human resources-related constraints in the public structures. The lack of remuneration, supervision and training for MPH personnel poses problems for human resources management. Increasing staff numbers, with additional qualified human resources (on MSF contracts) and closer supervision may be solutions for improving the quality of healthcare.
- Considering the persistent constraints affecting the MPH's health structures generally, there should be a re-evaluation of the benefits and drawbacks of working through the public health system as a whole and in specific health structures.
- Considering the sheer magnitude of the needs to be met, MSF-B is planning an exploratory mission to identify and prioritise medical requirements and to determine the best approach to adopt.
- Considering the high mortality due to malaria, MSF-B will be seeking to further improve access to effective treatment (artemisinin-based combination therapy, or ACT), particularly in remote and difficult-to-reach areas, and stepping up preventive interventions (treated mosquito nets) for vulnerable groups.
- Considering that other health sector actors and donors (World Bank, Coopération Belge, European Union) are preparing to take over support to public health structures in some health zones, MSF-B will be concentrating its efforts on the zones left uncovered. MSF-B will nevertheless be making a special appeal to these participants and contributors to keep the focus on the present-day humanitarian needs and vulnerability of the population.⁶
- The 'Congo emergency pool'⁷ will be maintaining an active presence to ensure rapid response in the event of an epidemic or other health problems.

⁶ MSF-B will, for instance, be stressing the need for adequate external funding and effective protection of vulnerable groups, to avoid a drop in current levels of access to healthcare.

⁷ The 'Congo emergency pool' ('Pool d'urgence Congo' in French, PUC for short) is an MSF team of national and international experts that does initial assessments and front-line response in the event of an epidemic outbreak. The PUC has been active since 1996 and at present has units in the provinces of Kinshasa, Equateur, Katanga and Province Orientale. In 2004, the PUC responded to 45 alert calls, an average of over three interventions a month.

Recommendations

❖ **It is crucial that national and international actors recognize the catastrophic humanitarian plight of a great majority of the Congolese people nearly three years after the signing of the peace accords.**

This recognition cannot be limited only to zones still in the throes of conflict. There are catastrophic health situations in zones unaffected by fighting, such as in Inongo health zone, which may be indicative of the situation in other rural areas. Needs in these zones are not being adequately met today. Owing to a lack of preventive measures and effective and accessible healthcare, common infections and epidemics continue to claim lives every day.

❖ **This catastrophic situation calls for an immediate response centred on the humanitarian needs of the population.**

Any response to the health situation in DRC must first and foremost be geared to meeting the medical needs of the population. Urgent action must be taken to reduce the catastrophic mortality rates. It is imperative that the medical interventions undertaken are the best ones for tackling these mortality rates. And the responses must not come second to concerns about sustainability or long-term development objectives.

In DRC, a **dual** approach to health matters is called for:

- provide a speedy and effective response to the current medical needs of the population
- build an equitable health system for the long term.

❖ **Free basic healthcare must be seen as an option for improving access to essential healthcare in DRC.**

Free healthcare must not be rejected as a matter of principle for the sake of development and financial sustainability considerations. MSF's experience in DRC shows that even a very low standard charge is not affordable for many patients. This is essentially due to the non-availability of cash, as well as to the subsistence economy in the rural areas of DRC. Reducing patients' financial contributions will not be enough to solve the problem of financial access to healthcare. People still have to have that rare commodity, money, with which to pay. A free healthcare system must be part of an overall framework including sizeable and regular grants to the health system from the state and from the international community. Motivating health personnel by paying them decent salaries is a key factor for the success of a free health service and access to healthcare.

❖ **Financing of the health sector in DRC must be regarded as a national and international priority.**

Reducing the mortality rate and improving access to healthcare calls for political will and a larger slice of the budget for health. There must be a national impetus, even though that in itself will not be enough. Even if DRC were to honour the commitments it made in Abuja and allocate 15% of the total state budget to health tomorrow, the amount would cover only one-tenth of the needs, according to WHO calculations on primary healthcare. The difference therefore must be made up by donors.

To the Congolese government, to the Congolese Ministry of Health, to health sector actors, to United Nations agencies, to NGOs and to donors in DRC:

On the basis of the arguments set out here, all of the actors in DRC must take account of the fact that far too many people are still dying. Priorities and modes of intervention must be modified accordingly.

In zones where conflict is ongoing:

- step up efforts to bring immediate assistance to the populations subjected to violence
- guarantee optimum access to healthcare by providing free medical care to all and by organizing mobile activities. This implies financing the full cost of medication and other supplies, as well as paying medical personnel decent salaries.

In rural zones unaffected by the violence:

- priority aid must go to the now abandoned regions where mortality rates are catastrophically high.
- basic healthcare must be subsidized so that it is available to patients free of charge so that effective assistance is provided.

To donors in particular:

Donors must continue to respond to the humanitarian needs of the people. Healthcare must be a priority in DRC given the health crisis.

At national level, there must be fundamental discussion on:

- the choices to be made on health strategy, to the benefit of patients
- the grant and subsidy policies to be implemented, to increase operational healthcare services in rural areas and to remove the financial barrier to patients' access healthcare in DRC.